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Utilization Management & the Comprehensive Services Act

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The Utilization Management Training Programs are under the auspice of:

The State Executive Council of the Comprehensive Services Act
The State Management Team of the Comprehensive Services Act

Conducted by:

The Commonwealth Institute for Child & Family Studies (CICFS)/
Department of Psychiatry/VCU

Sponsored by:

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Charter Behavioral Health Systems - Charlottesville
Middle Peninsula/Northern Neck CSB
Timber Ridge School
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Lonesome Pine Offices on Youth
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In Cooperation with:

VISSTA

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APPLYING UTILIZATION MANAGEMENT PRINCIPLES TO THE

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COMPREHENSIVE SERVICES ACT: A FEASIBILITY STUDY

EXECUTIVE SUMMARY

Description of the Study

The Commonwealth Institute for Child and Family Studies was commissioned by the State Executive Council to conduct a feasibility study on the application of utilization management principles to the service delivery system mandated by the Comprehensive Services Act (CSA). This study was designed to assess whether utilization management tools and strategies could enhance localities' ability to provide appropriate services to children with serious emotional disorders in a responsive and cost effective manner. A variety of assessment approaches including surveys, focus groups, child profiling methodology, and analysis of available data bases, were used to address questions related to the application of utilization management principles to the CSA. Data were gathered from key stakeholders including parents, providers, members of Family Assessment Planning Teams (FAPT), members of Community Policy and Management Teams (CPMT), and the State Management Team. Some information was collected on a state-wide basis while more indepth assessment was conducted at 12 localities that volunteered to participate in an intensive data gathering effort.

For the purpose of this study, we focus on one aspect of utilization management, decision support process, that is defined as follows:

> *A decision support process that provides pertinent information and guidance for individuals and organizations interested in designing, implementing, monitoring, and evaluating services on dimensions of appropriateness, quality, and cost effectiveness. Decision support processes may be used to facilitate service delivery at individual consumer level, or target population level, and to support an organized system of care.*

Findings

Data were collected and analyzed to address the following four questions:

1. How has the CSA affected the cost of service?

   Overall CSA costs have escalated from $104,500,000 in 1994, the first year of operation, to $144,600,000 in 1996, and increase of approximately 40%. During these same years, the number of children served has increased 37% from 9,536 to 13,063. Thus, the average cost per child has increased only 1% since the first year of CSA implementation, while the Consumer Price Index for services during the same time increased 7%. The increase in children served is accounted for primarily by changes within the mandated population which increased by 37% between fiscal years 1994 to 1996. Focus group participants identified a number of reasons for change in cost including: (a) increasing administrative costs for localities, (b) increasing number of children receiving services each year, and (c) CSA service philosophy which stresses provision of services to the entire family instead of just the identified child. The lack of money for needed preventative services was also identified as a fiscal concern by focus group participants. A significant portion of the increase in children served is attributed to the fact that CSA has increased awareness of service availability and raised expectations among families regarding what they might expect from the child services system.

2. Who are the children served by the CSA and how are they served?

Of the 13,063 youth served by CSA in 1996, 57% were male; 50% were white and 44% were African-American. The largest number of youth fell in the 13-17 year old range. The largest primary agency referral source was the Department of Social Services which accounted for 61% of all referrals. The most commonly specified service provided through the CSA in 1996 was regular foster care, followed by therapeutic services, residential services (at large treatment centers), special foster care, and education. Private providers were responsible for services provided to 82% of the youth while public providers served 18%.

Within the 12 localities that participated in the study, profiles were developed for a sample of 270 children with emotional/behavioral problems. These were children who, at the time of their most recent service plan review, were residing in, or were at imminent risk of being placed in, purchased residential care, and whose needs required the coordinated services of at least two agencies. Sixty percent of the children in the sample were male and most were white (44%) or African-American (43%). The median age was 15 years. Seventy percent of the children were in special education and 84% had some involvement with the Department of Social Services. Only 15% reported involvement with a single agency while 62% were involved with three or more agencies.

At the time of the most recent FAPT meeting, 59% of the children (n=160) were living in homelike placements while 41% (n=110) were in nonhomelike placements. Child profiles were based on the Childhood Severity of Emotional/Behavioral Disorders (CSBED) which assesses a child in four domains: symptoms, risks, functioning in various settings, and other needs/problems. In addition, this instrument provides an estimate of caregivers' and communities' readiness to care for a child. Within the total sample, 63% of the children behaved in a manner that presented serious or severe risk to harm self or others. Of those living in a homelike setting, 58% exhibited an acute level of risk. In comparison, 70% of children in nonhomelike settings exhibited recent or acute risk behavior, with 23% having a history of risk and 7% showing no risk at all. Eighty-five percent displayed high levels of symptomatic behavior. This finding may be viewed as a confirmation that the CSA is, in fact, serving very troubled youth. Likewise, according to the CSBED, the children had high levels of dysfunction (72%) and other serious problems (70%). Children placed in homelike and nonhomelike settings do not differ significantly on these dimensions.

3. What are the child and system characteristics that seem to influence CSA practices?

When asked which factors influenced placement decisions for the 110 children placed in residential care, case managers identified the following: the child was unsuccessful at all less restrictive placements (n=79); unavailability of community resources to provide the necessary level of supervision (n=68); and the lack of services in the community (n=42). According to case managers, the primary reasons for being able to maintain 160 children in the sample in a homelike setting included: availability of adequate in home support (n=94); availability of appropriate education services (n=87); child's clinical status was mild or moderate (n=76); utilization of flexible funding for special

services (n=59); appropriate day treatment services (n=42); and availability of special foster care (n=34).

Stakeholders' perceptions were assessed via Parent and Student Satisfaction Questionnaires. Forty-one parent and 49 student questionnaires were returned. Parents and children were satisfied with most aspects of the services that they have received since the enactment of the CSA. Sixty-three percent of the parents were pleased with their children's improvement and 78% of the children were satisfied with their own progress. In addition, over three-fourths of the parents (78%) and children (84%) surveyed believed that they were receiving some or all of the services that they need.

In response to the question of whether appropriate fiscal incentives exists to promote clinically sound and fiscally prudent decision making on behalf of children in need of services, focus group participants cited several factors that serve as disincentives for provision of appropriate, cost effective services. The fact that communities are able to avoid spending money on services by placing a child in a state institution was cited by several participants. The ease with which non-CSA payors/managers, such as managed care companies, can offset their costs by referring children to CSA poses another serious fiscal disincentive. Focus group participants also noted that children are often placed in the custody of DSS in order to make them eligible for services. This adds to both the cost of services and emotional distress of children and families.

Focus group participants suggested that a number of additional positive incentives to be considered, including increased flexibility of funding for program startup and a provision to allow localities to keep money saved in order to reduce costs and to reinvest in prevention/early intervention programs or other services. Focus group participants also encouraged the promotion of funding arrangements that would allow providers to share risks as well as benefits with localities.

Factors that appeared to be related to cost or service patterns state-wide were population density, percentage of children in poverty, and growth in the number of children in foster care. These three variables accounted for 44% of the variation in 1996 CSA per child cost. Localities that had higher costs per child in 1996 tended to be more densely populated, to have few children in poverty, and to have more growth in foster care.

4. How can utilization management tools be applied to placement decisions?

Lyons (1996) has proposed a model of utilization management, the Level of Care Decision Support Guidelines (DSG), which assists in matching children's placement with child and caregiver characteristics. The DSG was used to identify expected placements for the 270 children in this study, and the expected placements were compared with the children's actual placements. The DSG placement matched the actual placement 54% (n=147) of the children sampled. Only 24% (n=75) were placed in more restrictive settings and 18% (n=48) were actually in less restrictive settings than expected according to the DSG.

An examination of the reported behavioral and emotional strengths of children sampled revealed one potential explanation for this discrepancy. In youth for whom the DSG recommended a homelike placement, those who were actually placed in nonhomelike settings had lower total BESS strengths that did those actually in a homelike setting. In youth for whom the DSG recommended nonhomelike placement, those who were actually

placed in homelike settings had higher strengths that those in nonhomelike settings. Thus, it may be that behavioral and emotional strengths of children are a mediating factor in the consideration of placement.

In order to account for the discrepancies between the DSG and actual placement, the impact of per child cost was examined. Localities were classified as "high cost" if their per child costs in 1994, 1995, or 1996 were above average for the state. With similar patterns of symptoms and risk, children were placed out of home 55% of the time in high-cost communities, while they were placed out of home only 30% of the time in low-cost communities. To investigate this trend further, children were classified into the following groups: high symptoms/low risk, high symptoms/medium risk, high symptoms/high risk, and low symptoms/low risk. According to DSG, children in lower symptoms/risk categories should be placed out of the home less often than children in higher symptom/ risk categories. This appears to be occurring in low-cost but not in high-cost communities. Factors other than symptoms and risk, which are not currently identifiable, seem to influence placement decisions in high cost localities. This suggests an opportunity for utilization management to help control costs in higher cost communities.

Finally, another reason why DSG placements may not fully match actual placements is that the DSG does not consider all of the information available to case managers and other decision makers which could affect placement decisions.

A survey of views of the application of utilization management principles to the CSA was distributed to CPMT and FAPT members as well as private providers and parents. Respondents (n=489) indicated that more attention should be given to providing fiscal incentives that encourage the delivery of appropriate, cost effective services and to making available funding and technical support for prevention and early intervention programs. The need for developing local resources for children and families was also frequently cited. While half of the respondents indicated they favored giving localities a choice of whether they would participate in utilization management, a comparable number of respondents expressed a favorable attitude toward requiring localities to participate in a system which would allow them to determine the specific decision support tools they would employ.

Conclusions

Based on findings of this study, we reached the following overall conclusions:

- The CSA is achieving many of its primary objectives with regard to children with serious emotional/behavioral problems.
- Application of utilization management principles to the CSA is feasible and would be welcomed by most stakeholders.
- There is an urgent need to enhance the ability of localities to collaboratively develop and provide a comprehensive, family centered community based system of care.

Several alternative structural models were considered for applying utilization management principles to the CSA. The two most viable alternatives appear to be:

- All localities shall use utilization management processes and each locality can choose from a range of specified options.
- All localities shall use a common utilization management process with

administrative support, i.e. data analysis and critical pathway guidelines, provided by a central entity.

Under both of these options, service resource allocation decisions remain at the local level.

Recommendations

In order to assure that children and families served by the CSA program receive cost effective, quality services that are appropriate to their needs and strengths, we urge the State Executive Council to give serious consideration to implementing the following recommendations:

- Develop a comprehensive system of utilization management process that is consistent with CSA principles.
- Establish fiscal incentives to encourage localities to develop an array of community based services.
- Develop and promote a service contracting process that enhances accountability and strengthens the public/private partnership through credentialing standards and performance criteria.
- Enhance and clarify the role of case manager as a critical agent within utilization management system.
- Promote and support performance improvement initiatives that enable localities to operate in a more efficient and responsive manner.
- Develop comprehensive training and technical assistance programs to enhance localities' capacity to provide cost effective services that are consistent with CSA principles.

Immediate priorities for implementation should be: (a) creation of a comprehensive decision support system, (b) enhancement of localities' capacity to develop community based systems of care. The following actions will he required to achieve these two goals:

- Designate or establish an advisory council to oversee the training and technical assistance process. This might be done under the auspice and leadership of the State Management Team.
- Review utilization management/decision support alternative and select the approach(es) most likely to achieve service quality and cost objectives while maintaining service principles, i.e., empowerment of localities and support for family centered services.
- Develop an action plan for implementing specific utilization management strategies.
- Establish a comprehensive training and technical assistance program to enhance stakeholders ability to participate effectively in utilization management processes and to develop family centered systems of care at the local level.
- Establish a model for gathering, organizing, and reporting information that supports monitoring effectiveness on dimension of clinical outcomes, consumer service, and cost effectiveness.
- Identify locality specific needs for assistance.
- Develop and implement an action plan, including an evaluation component, for providing training and technical assistance for the next 12 months.

SUMMARY

This study found many parts of the CSA to be meeting the original intent of the Act. Stakeholders generally felt that the system was better than it was before the CSA. To continue to meet the goals of the CSA, recommendations were offered to support the

implementation of a comprehensive utilization management process, the development of specific fiscal incentives, and the provision of technical assistance and training.

Guidelines For Assissting Localities To Provide Appropriate, Cost Efficient Services For Children and Families Served by the Comprehensives Act (CSA)

Introduction

Health and human service delivery systems throughout the country are experiencing considerable pressure to enhance accountability and control costs. A variety of approaches have been used to accomplish these goals. In some instances, external entities such as managed care organizations have been brought in to manage utilization and cost of services. In other cases, policy makers and funding sources have chosen to work within the existing decision making structure, developing guidelines and data bases that facilitate rational planning and prudent decision making among those responsible for delivering health and human services. The Comprehensive Services Act [CSA] was enacted by the General Assembly in 1992 for the purpose of improving care for troubled and "at risk" youth and families, as well as to control the escalating cost of residential treatment for this population. While much progress has been made, concerns about the overall increase in cost as well as concerns about out-of-home placements instigated the State Executive Council to commission the Commonwealth Institute for Child and Family Studies to conduct a feasibility study. The study focused on the application of utilization management principles to the service delivery system mandated by the CSA. Data were gathered from key stakeholders including parents, providers, FAPT members, CPMT members, and the State Management Team. Based upon the data gathered from feasibility study, it is apparent that there is need and support for utilization management.

In the feasibility study it was found that even with the implementation of CSA, the gross cost for services has continued to increase. This overall increase in cost makes it necessary to continually assess the functioning of the CSA in order to improve cost-effective performance. In designing a utilization management strategy for the CSA, the State Executive Council took into account the CSA's strong emphasis on retaining responsibility and authority at the local level as well as its focus on individualized service planning. The Council has chosen a utilization management strategy that supports local empowerment and accountability through a decision support process that provides pertinent data and guidance to individuals and groups responsible for service planning. This decision support system is based on the conclusions of the feasibility study, which generated the following principles:

- Decision making authority should remain with the locality.
- Decision makers, including consumers, FAPT, and CPMT members need to have a rational basis for assessing child/family needs/strengths and matching them with the most appropriate services.
- The guidelines need to be sufficiently flexible to account for uniqueness of each locality and the current capacity of caregivers and communities to respond to children with emotional/ behavioral disorders.

- The utilization management system must strike a balance between providing responsive, appropriate services, and being sensitive to the limited resources available to meet the needs of the many children and families requiring services.

- The system should distinguish between level of placement, i.e., psychiatric hospital, residential, group home, family, and intensity of service, with both factors being important but not necessarily interdependent. For example, for some children it is possible to provide intensive services while they remain at home, thus providing a less restrictive environment for the child while also potentially reducing the cost of services.

The following guidelines and processes have been developed to assist localities in assessing child and family needs and strengths, developing viable service plans, and implementing these plans in a responsive, cost efficient manner. In keeping with the principles of the CSA, these guidelines are not intended to provide localities with a formula-based decision making process, with rigid exclusionary criteria that result in a child being found eligible or ineligible for services. Instead, the system is designed to give decision makers a child and family-centered rational framework for assessing the most appropriate care for a given child and family. The guidelines provide a template for determining which level of need, services, and placement might be most suitable for a child and family with specific characteristics. In keeping with the child/family-centered framework, consideration of mitigating circumstances is an important part of determining the most appropriate services and placement for the child and family. These guidelines are applicable for all children who receive CSA services beyond basic maintenance for foster care children and a minimal service level. These guidelines shall, however, take into account and be applied in a manner that complies with agency requirements for specific populations, i.e., special education.

We suggest that you use these guidelines similarly to how one would use a road map. Knowing that there is a direct route to one's destination may be helpful, but having first hand knowledge of road conditions, weather, and other factors may lead one to select an alternative route which may prove to be faster, safer, and even less costly than the suggested pathway. The CSA decision support guidelines provide a framework that enables local stakeholders, including family members, to work together in a rational, accountable manner to provide responsive, cost efficient services for children. While the guidelines should facilitate this process, they are not a substitute for sound knowledge and understanding of the needs and strengths of children and families and unique conditions of local communities.

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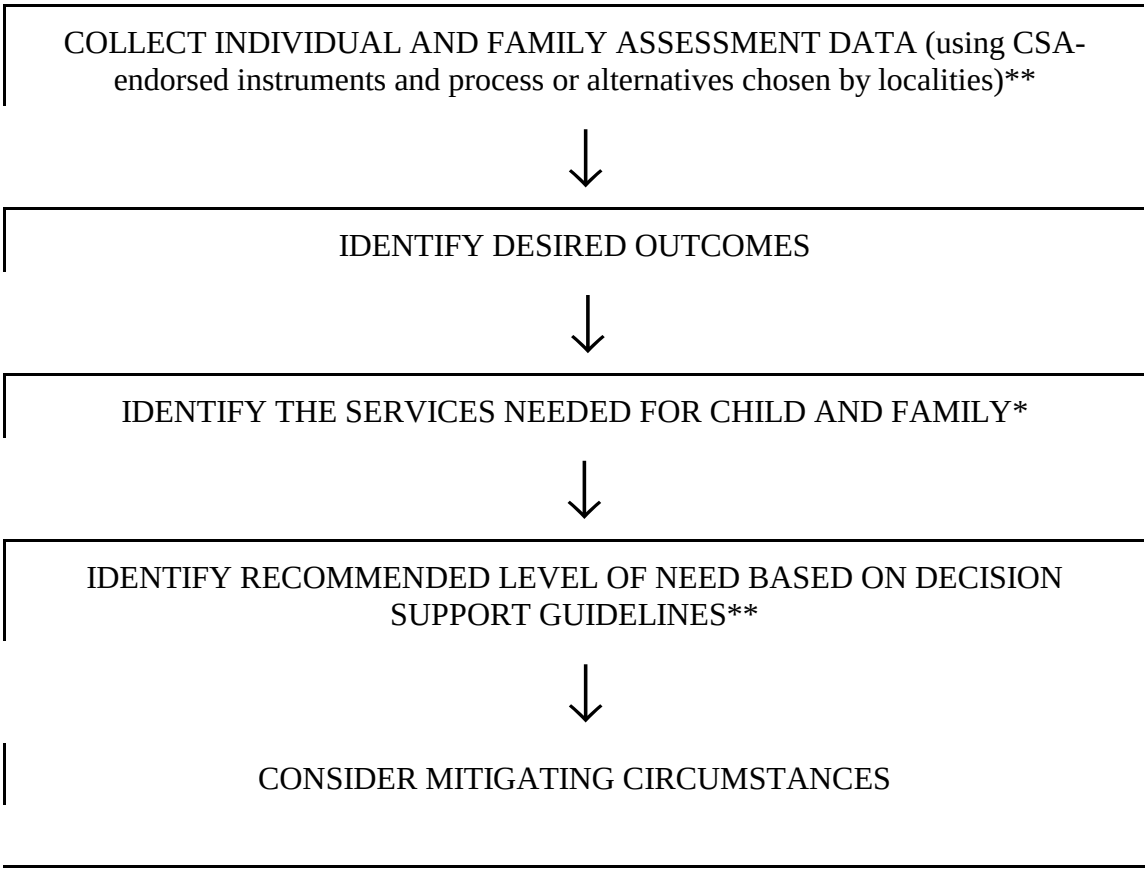
Summary of Utilization Management Implementation Process For Services Provided Under the Comprehensive Services Act (CSA)

During the 1997 budget process, the General Assembly added a requirement that all Community Policy and Management Teams [CPMTs] must incorporate utilization review of residential placements utilizing CSA funds in order to be considered for supplemental funding. For those who choose to participate in this utilization management process, the required criteria are listed below. The requirement provides local government options when considering which utilization review technology they intend to employ. Localities may choose the CSA endorsed guidelines, which are located on pages 11-16, or they can create their own guidelines that follow the criteria below. Localities also have the option of choosing how to implement the utilization review process. Those following the CSA endorsed guidelines may either manage this process on their own, or receive assistance at no cost from West Virginia Medical Institute [WVMI], the organization that provides utilization review for the Department of Medical Assistance Services. Those who choose to create their own guidelines may either manage the utilization review process internally, or contract with a utilization review organization. While the legislative requirement applies only to residential placements, localities may also conduct utilization processes for other children whose intensive and multiple needs make them appropriate for CSA services.



FINALIZE THE CHILD SERVICE PLAN

NEGOTIATE WITH PROVIDERS, INCLUDING CLARIFICATION OF EXPECTATIONS FOR FAMILY INVOLVEMENT AND EXPECTATIONS FOR MONITORING OF PROGRESS

IMPLEMENT PLAN, INCLUDING PLACEMENT AT THE IDENTIFIED LEVEL OF NEED AND PROVISION OF PRESCRIBED SERVICES

PERIODIC REGULAR REVIEW OF CHILD AND FAMILY PROGRESS TOWARD TREATMENT GOALS* (after time period specified in Level of Need chart)

POSSIBLE ACTIONS AS A RESULT OF REVIEW (Repeat the **Decision Support Process**, if indicated, to assist in evaluating and revising the current plan)**:

- · continue to follow the current plan
- · change length of time for current service(s) and objectives
- · change service objectives
- · change aspects of the environment
- · change provider
- · change treatment modalities at same level of need
- · change placement
- · change level of need

*Decision Support Guidelines need to meet CSA's general criteria for decision support processes. Localities may choose from other measurement instruments that are validated and appropriate for the utilization management of child and family services (i.e., Child and Adolescent Functional Assessment Scale - CAFAS).

**SYSTEM-LEVEL UTILIZATION MANAGEMENT: The above outlined utilization management process may be followed at both an individual level and at a larger system level. Components of the utilization management process can be compiled for all CSA cases in the locality and analyzed to review the process at the system level. Such a system level review would entail summaries of:

(a) characteristics of children and families;
(b) recommended services for CSA cases;
(c) levels of care recommended by decision support guidelines;
(d) mitigating circumstances overriding recommended level of care;
(e) decisions regarding levels of care for CSA cases;
(f) child and family progress toward treatment goals;
(g) changes in level of care as a result of review of progress.

Opening Group Exercise

Please answer the following questions according to your localities structure of individual child and family utilization management:

☐ Y ☐ N Does your locality collect individual and family assessment data?

☐ Y ☐ N Does your locality identify desired outcomes?

☐ Y ☐ N Does your locality negotiate for the provision of services based on desired outcomes?

☐ Y ☐ N Does your locality ensure the involvement of parents?

☐ Y ☐ N Does your locality place children at an identified level of need based on assessment data?

☐ Y ☐ N Does your locality check on the prescribed services?

☐ Y ☐ N Does your locality ensure the required utilization review?

☐ Y ☐ N Does your locality have a back-up plan for the child's treatment plan if the outcomes are not being met in a timely manner?

☐ Y ☐ N Does your locality transition children to less restrictive services if the outcomes are being met?

☐ Y ☐ N Does your locality have a person (staff/agency/vendor) who will be responsible for the transition planning to less restrictive services?

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Service Planning Chart

Completed by: Date: Case #:	(A) CHILD & FAMILY STRENGTHS	(B) CHILD & FAMILY NEEDS	(C) LONG RANGE OUTCOMES (2-3 YEARS)	(D) SHORT TERM OUTCOMES (3 MONTHS)	(E) STRATEGIES TO MEET SHORT-TERM OUTCOMES	(F) LEVEL OF NEED - OR - LOCAL D.S.G.	(G) MITIGATING CIRCUMSTANCES	(H) FINALIZE SERVICE PLAN
HOME: safety, living arrangements, relationships.								
SCHOOL: learning needs, safety, peer relationships, extra curricular activities, vocational training.								
COMMUNITY: friends, community norms,neighborhood relationships,church, safety, recreation.								
HEALTH: child and family issues, medical problems.								
LEGAL: custody issues, involvement in judicial system, need for SSI.								
BEHAVIORAL: risk to self and safety of community								
EMOTIONAL:								

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Participant's Vignette - Jennifer

Jennifer is currently 13 years old. She is the oldest of three children who were born in New York. The mother moved to Virginia in the mid 1990's to leave an abusive relationship. Jennifer has Type I Diabetes. Mother is a substance abuser with a history of being involved in physically abusive relationships. The mother loves and cares about her children but is unable to care for them. Mother is borderline MR, and even with wrap around and supportive services she is unable to provide housing and deal with medications. In July, 1996 the children were removed from their mother's custody for founded neglect charges. Father is unknown.

Jennifer was sexually molested in June, 1996 by a "friend" of her mother's. She has had a history of multiple acute hospitalizations since early 1997 and is currently in a residential placement in a psychiatric hospital. She has a history of self harm, homicidal and suicidal threats, oppositional defiant behavior, verbal and physical aggressions toward peers, sexual abuse and sexual acting out. She has also threatened and abused her younger siblings. Jennifer's intellectual functioning falls in the borderline range and she is LD. She had been receiving special education services in the local public school system. Jennifer requires multiple repetitions for learning and does not learn well through experience. She seems to sabotage her gains in functioning. She remained in a foster home until June, 1997.

While in foster care Jennifer received intensive intervention services from a local home based provider to assist with stabilizing and providing the support she needed both at school and in the community. However, after she testified against her molester in court she experienced a major decompensation and her behavioral problems became so severe she was placed in a residential unit at a local psychiatric hospital. She is still hospitalized. The home based provider continues have face to face and phone contact with Jennifer several times a week. This provider has also taken her on a community outing and feels Jennifer is making progress. On her outing in the community her behavior was appropriate and she responded well to redirection when needed. The home based workers encourage Jennifer to participate with treatment by promising additional community outings when her behavior is appropriate. The in home provider continues to provide encouragement as well as positive reinforcement to assist Jennifer with making good choices. Jennifer recently began to show improvement in her hospital program and made level 2 in her treatment. However, she has been unable to maintain that level and is back on level one. Communication between the hospital staff and the home based provider has been excellent. The home based provider is trying to find a less restrictive placement for Jennifer and has contacted a number of local therapeutic foster care agencies. So far, these agencies have not had available homes which can meet Jennifer's needs.

The home based provider has located a potential foster parent, Ruth, a single woman who is willing to began the training process. Ruth has met with members of the FAPT and has been invited to the next FAPT meeting. Ruth will also meet with hospital staff to become updated on Jennifer's treatment and issues. The home based provider will continue to work with Jennifer to address issues such as positive socialization skills, self-esteem, and to support her transition to a home in the community.

Current diagnosis:

- Major depression with psychotic features
- Post traumatic stress disorder
- Mild Mental Retardation
- Type I Diabetes

Current Medications:

- Adderall
- Zyprexa
- Visteral
- Insulin

Current CAFAS Rating:

- 110

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Levels of Need (Revised by OCS July 22, 2003)

NOTES:

a) **The following Levels of Need chart, characteristics, and specific CAFAS criteria have not been proven to be an appropriate predictor of placement.** No empirical data has been gathered to confirm that this is a proven method for correct placement. It is not intended as a formula for placement, it is merely guidelines to be followed while making decisions for each case.

b) **If a child does not reach the minimal Level 1 score on the CAFAS (50-90), it does not mean that they can not receive services from the CSA.** These utilization management efforts are focused on the population of children who have intense needs and are involved with multiple agencies. Other children who receive early intervention and prevention services can still receive CSA services. These children are not subject to the level of need decision support process requirements.

c) **Begin consideration at the lowest Level of Need and the least restrictive placement**. A child who meets characteristics at a high level may utilize services/placement at a lower level as appropriate. Lack of expected progress should not automatically indicate movement to a higher Level of Need. All options and resources within a lower level should be tried before moving to a higher level.

d) **The minimum review period is stated as a guideline for the greatest amount of time that should pass before the reassessment of the child and family receiving services.** This review period is a suggestion and the frequency of reviews should be based on the individual needs of the child. For example, children who are in need of a change of services may require more frequent sub-reviews by the professionals responsible for the case. Persons involved in the review will vary depending on the child's level of need and placement. For children receiving services at levels 1 - 5, formal reviews will be performed periodically by FAPT or equivalent assessment teams. In addition, more frequent reviews should be conducted by the specialist responsible for the case. These evaluators are to be determined by the community responsible for the treatment plan of the child. For children receiving services at level 6, the daily evaluation should be conducted by the specialist(s) who are most familiar with the specific needs of the child.

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Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child Score	CAFAS/PECFAS Family/Social Support Scale Score	Level Specific Program Components	Primary Caregiver Options	Minimum Review Period
1	Moderate impairment in child's functioning. · Child has emotional or behavioral problems requiring intervention which are significantly disabling and are present in several community settings. · Child needs services or resources which require coordination by at least two agencies. · Child qualifies for special education and/or is otherwise mandated for services through CSA. · Child responds positively to structure and interventions and demonstrates low risk of harm to self or others.	N/A	50-90	<20	Community-Based Interventions: · Afterschool · Respite · Mentor · Parent aide · Personal care assistance · Case management · Outpatient treatment, including family treatment · Facility-based crisis intervention (e.g., emergency or crisis shelter) · Behavior management program · Day treatment · In-home services <11 hours/week	· Parents' home · Relative's home · Foster care home · Independent living	3 months

Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child	CAFAS/PECFAS Family/Social Support Scale	Level Specific Program Components	Primary Caregiver Options	Minim Revie Perio

Revised by OCS, July 22, 2003

			Score	Score			
2	Moderate impairment with moderate risk factors. · Needs intensive supervision to prevent harmful consequences · Moderate/frequent disruptive or noncompliant behaviors in home setting which increase risk to self or others · Needs assistance of trained professionals as caregivers	Any risk factor: CAFAS items 3, 4, 43, 68, 69, 71, 77, 78, 89, 90, 119, 142-148 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152, 154-155	100 or higher	20 or higher	· Community-based interventions (as above) plus: · In-home services > 10 hours/week, including family focused services · Intensive partial hospitalization · Treatment foster care · Therapeutic preschool · Intensive behavior management program · Behavioral aide services	· Parents' home · Relative's home · Foster care home · Independent living · Specialized foster home · Professional treatment home	3 mon
3	Significant impairment with problems with authority, impulsivity, and caregiver issues. · Unable to handle the emotional demands of family living · Needs 24-hour immediate response to crisis behaviors · Severe disruptive peer and authority interactions that increase risk and impede growth	N/A	100 or higher and Community Scale: 30 or higher	30	Level 1 and 2 services, plus: · Therapeutic milieu with individual treatment components · Family treatment · Low-level residential placement with least restrictive educational placement and family treatment · 24 hour supervision	· Parents' home · Relative's home · Foster care home · Independent living · Specialized foster home · Professional treatment home · Group home · Crisis home · Wilderness program	2 mon
Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child Score	CAFAS/PECFAS Family/Social Support Scale Score	Level Specific Program Components	Primary Caregiver Options	Minim Revie Perio
4	Significant impairment with severe risk factors. · Demonstrates risk behaviors that	At least 1 severe risk factor: CAFAS items 3, 4, 71, 89, 119, 142-	140 or higher	N/A	Level 1, 2, and 3 services, plus: · Day nursing coverage · Discharge planning, from	· Parents' home · Relative's home · Foster care	1 mon

	create significant risk of harm to self or others	144 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152			time of admission, for return to community · Intensive behavior management program	home · Independent living · Specialized foster home · Professional treatment home · Group home · Crisis home · Wilderness program · Campus-style residential treatment center · Boot camp	
Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child Score	CAFAS/PECFAS Family/Social Support Scale Score	Level Specific Program Components	Primary Caregiver Options	Minim Revie Perio
5	Severe impairment with severe risk factors. · Needs secure intensive treatment because of (1) demonstrated, persistent inability to be managed safely in a less structured setting (2) severe dysfunctional symptoms which require intensive interventions · Needs ready access to psychiatric care · Needs specialized programs to address symptoms and/or specific diagnostic areas	At least 1 severe risk factor in the past month: CAFAS items 3, 4, 71, 89, 119, 142-144 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152	140 or higher	N/A	Level 1, 2, 3, and 4 services, plus: · Intensive psychiatric components (2-3 times/week), including individual and group therapy · Ready access to child psychiatrist · 24 hour direct nursing supervision · Discharge planning, from time of admission, for return to community · Intensive behavior management program	· Secure residential treatment program	1 mon
	Acute severe risk factors OR acute medical issues.	At least 1 severe risk factor	N/A	N/A	Level 1 and 2 services, plus: Daily reassessment	· Psychiatric hospital	Daily (r factors

6	· Acute risk of harm to self/others · Requires constant observation · Other acute medical needs · Acute psychiatric issues requiring evaluation/observation	within the last 3 days: CAFAS items 3, 4, 71, 89, 119, 142-144 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152			· Daily therapeutic treatment services · Locked unit · 24 hour nursing coverage; direct medical services · Exam by psychiatrist qualified to treat children · Immediate family and community involvement · Immediate discharge planning · Psychological evaluation reviewed, updated or completed · Intensive behavior management program		only)

Mitigating Circumstances to Be Considered in Placement Decisions

Mitigating circumstances may provide a rationale for selecting certain services and/or placements over others. The following list is not meant to be inclusive. Individual cases often present unique and challenging circumstances which contribute to the amazing capacity to provide community-based care. Certain mitigating circumstances may also warrant consideration of more restrictive placements than those identified after initial assessment.

System Factors

- Placement safety.
  The degree to which the placement is safe and does not present a risk of harm, neglect, or abuse for the child.
- Community safety.
  The degree to which the community would be at risk of harm from the child.
- Community capacity for WRAP.
  The degree to which the community possesses the knowledge, skills, and/or resources to provide WRAP services. WRAP services are defined as interventions that are "developed and approved by an interdisciplinary service team, are community-based, and unconditional, are centered on the strengths of the child and family, and include the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family (The International Initiative on Development, Training, and Evaluation of Wraparound Services, 1992, p. 1)."
- Ability of agencies to work together.
  The degree to which multiple agencies are willing and able to coordinate services to meet the child's needs and to facilitate the child's progress.
- Community attitude towards children with serious emotional disturbances.
- Legal constraints.
- Resources of the community.

Individual Factors

- Ineffectiveness of current treatment.
- Child's unwillingness to cooperate with treatment.
- Family preferences for or against particular treatment modalities.
  Family needs and preferences must be considered in the planning and provision of services. With the exception of extenuating circumstances, the provision of services is contingent upon family acceptance. However, family and cultural preferences may preclude certain services. Refusal of services does not necessarily move the child to a higher level of need, but may warrant negotiation of different services and/or placements at the same level of need.
- Resources of the caregiver, family, and extended family.

Description of WRAP Services

The International Initiative on Development, Training, and Evaluation of Wraparound Services (1992) defined Wraparound Services as:

> *interventions that are developed and approved by an interdisciplinary service team, are community-based, and unconditional, are centered on strengths of the child and family, and include the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family.* (p.1)

Examples of WRAP Services

THERAPEUTIC
Early Interventions
Counseling and Therapy Services
Home Based Services
Day Treatment
Therapeutic Nursery Program
Non-Residential Emergency Services

INSTRUCTIONAL
Regular Classroom
Resource Room
Self-Contained Classroom
Special and Alternative Schools
Homebound
Related Services
Life Skills Training
Social Skills Training

HEALTH CARE
Health Promotion
Primary Care and Screening
Acute Medical Care
Chronic Medical Care
Dental Care

VOCATIONAL
Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement and Retention Services
Supported Employment
Sheltered Workshops

RECREATIONAL/SOCIAL
Neighborhood Program
After-School Program
Summer Camps
Special Recreational Projects
Self-Help and Support Groups
Community Service
Individualized Skills Training

FAMILY
Respite Care
Parent Education and Family Support
Meditation
Family and Parent Counseling
Home Aid Services
Relatives, Friends, Spiritual Affiliations
Shelter
Therapeutic Camp

SUPERVISORY/PROTECTIVE
Diversion
Probation
Intensive Supervision Services
Outreach Detention
Child Protective Services
Individual Supervisory/Support Staff
Maundering

OPERATIONAL
Assessment
Service Planning
Case Management
Advocacy
Transportation
Legal Services

SUSTENANCE SERVICES
Housing
Food
Clothing
Financial Services (e.g., food stamps, AFDC, Medicaid, WIC, SSI, fuel assistance)

Utilization Review Questions

Has progress been made in meeting the identified outcomes?

Has progress been made in meeting the identified service objectives?

Have you verified the delivery of service(s)?

Have you verified the quality of service(s)?

Have there been changes made in the child's service plan (i.e., medications, education services, amount and/or type of mental health counseling)?

Has a current CAFAS score been calculated?

Has there been a review of child's current level of functioning?
If yes, have changes baan made in child's plan to reflect it?
If no, when is the next scheduled review?

Are appropriate steps being taken if outcomes are being met?
a. Plan to transition child to a less restrictive setting
b. Time lines to transition child to a less restrictive setting

Are appropriate steps being taken if outcomes are not being met?

When is the date for the child's next utilization review?

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